tion and sloughing, with an amount of destruction of pelvic connective tissue around the lower end of the gut, which is often irreparable; and when the patient does recover he is liable to permanent disability.

I was consulted recently by a healthy-looking Western gentleman, in middle life, who was about to marry a second time, for occasional inability to prevent escape of flatus from the anus, and when his bowels were loose he was also liable to incontinence of fæces. He had been operated upon twenty years before for fistula, but, through his own neglect, the disease was not cured Other abscesses followed, one of which was very severe and extensive, and it left, after long convalescence, several new fistulous tracts. These were subsequently laid open at different operations, and all healed soundly. On examination I found the anal orifice retracted much more deeply between the nates than usual; indeed, vigorous pulling asunder of the buttocks was required to bring it into view. It was formed posteriorly by a dense cicatrix, and a slight protrusion of mucous membrane presented. There was no grip to the sphincter, which had evidently been seriously damaged. There had been also, pretty certainly, extensive loss of substance of the pelvic connective tissue around the lower end of the rectum, and powerful contraction of the granulation tissue during repair. The excessive retraction of the anus was also in part due to the constant use of the *levatores* in efforts to aid the weakened sphincter in retaining the contents of the bowel. The parts presented the appearance which might have followed entire removal of two inches of the lower end of the rectum, including the anus. Recognizing no prospect of benefit from operative interference, I advised palliative measures, amongst others the wearing of a small plug of prepared oakum moulded to the part.

The result of another case which I saw some years ago was even less favorable.

A gentleman of 47, of good constitution, but sedentary, luxurious, and self-indulgent in his habits, developed a deep ischio-rectal abscess without any obvious cause. The symptoms were serious, and the surface induration excessive. His usual attendant, who watched the patient assiduously, discovered some soft, imperfectly fluctuating points towards the end of the third week, and made small punctures. Ulceration and sloughing followed, and when I saw the case later there was a gap several inches deep extending pretty much from the coccyx to the base of the scrotum, and this was being dressed in daily with lint. The granulations were feeble, and the patient's vitality very much depressed. Syringing with aromatic wine and painting with balsam Peru and comp. tinct. of benzoin were substituted for the lint dressing, and a general supporting treatment adopted. Under this course the patient gained, but very slowly, and declining the advice to take a sea voyage as offering the best chance to stimulate his flagging powers of repair, went to the country at the end of six weeks to avoid the summer heats, where some months later I saw a notice of his death—from exhaustion. In this case I formed the opinion, in consequence of the utter lack of vital force of the patient, that a depraved condition of the blood, and, in fact, of the whole organism, from a long-continued, faulty mode of living, was the cause of his attack, and I feel confident that this form of abscess comes often in a similar way.

There is, plainly, a wide interval between the little, round, painful abscess of the margin of the anus and the grave forms of disease just described, and in practice we encounter many varieties of abscess intermediate with these which I have brought forward as typical examples; but it is worthy of being always borne in mind that the same rule of treatment is imperative in all abscesses near the anus or rectum, viz., to open early and freely, with the double object of shortening the period of pain and tissue destruction, and of securing a cure, if possible, without fistula.

Troublesome bleeding from opening these abscesses rarely occurs. Pressure applied in the usual method, by compresses and a T bandage, or strips of adhesive plaster, is always available, but I prefer the sub-sulphate of iron—used either in solution, or as a dry powder. I have found this substance entirely efficient as a hæmostatic, and it makes a good dressing—possessing no irritating or escharotic properties, but, on the contrary, being an excellent disinfectant, and a salutary local stimulant. It forms a scab under which healing goes on without pus formation. I have filled the cavity of an abscess with the dry powder, blowing it in through a tube, after the manner recommended by Marcus Aurelius Severinus for his famous "catagmatic powder," with excellent effect. There is no reason, therefore, why the abscess should not be opened so freely as to render any subsequent retention of pus impossible, and this is the condition on which prompt healing and escape from the formation of a fistula depend. I have little doubt, after the results I have seen from the antiseptic method, that if it were faithfully used in opening and dressing these abscesses, and accurate drainage secured by means of caoutchouc tubes or horse-hair, healing without fistula would be the rule, instead of the rare exception, as at present. The striking success of Volkmann, as set forth in his recently published operations upon the rectum, certainly justifies this hope. But even with the aid of antisepsis in insuring prompt repair, early and free opening cannot be dispensed with.

There is a variety of abscess properly mentioned here which constitutes an exception to the rule I have just laid down, and our knowledge of it is both recent and valuable. The cavity beside the rectum, familiarly known as the *ischio-rectal fossa*, was first accurately described, and this name given to it, by Velpeau, in 1829. In 1856 Richet first pointed out and described formally a region lying beside the rectum, but *above* the ischio-rectal fossa, and separated from it by the levator ani muscle and the faciæ which line its surfaces. This musculo-membranous diaphragm forms at the same time the roof of the old fossa and the floor of the newly-described